STATEMENT
by
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I feel privileged to have been invited to participate in this special committee hearing on aging. I thank you for the opportunity to provide testimony and to be of service,

I am a licensed **Registered Nurse with in the State of California.**

In my current position, it is my responsibility to survey and monitor health facilities for compliance with State and Federal regulations, write reports, investigate complaints regarding patient care and services, issue citations when indicated, investigate adult/elder abuse, assist providers with clarification of regulations, I continue at this time as a Health Facilities Evaluator Nurse with the State of California. I have substantial experience and service in the nursing profession.

As a surveyor in the skilled nursing facilities my experience has been both, a very rewarding experience, but also a very frustrating process. The reason is because we have regulations to go by, but sometimes we can't enforce the very regulations that are violated. The final decisions regarding the determinations of the survey team are made by supervisors and administrative staff who may not have a medical background or current training.

In California, the typical survey is conducted by a team of 3-4 surveyors depending on the size of the facility. One person is designated as a team leader or team coordinator and that person usually handles the paperwork involved. The team may consist of 3 RN's and one generalist or all RN's. The generalist focuses on environmental and physical plant issues, while the RN's focus on medical issues. Sometimes the generalist is also a licensed nurse, and does both tasks accordingly.

The first thing we do before going out on a survey is an "off-site prep." In this task we review the previous survey to get an idea of the possible deficient practices and history of the facility. We review computerized reports (OSCAR, ODIE) with data that goes back at least 3 years so we have a fairly good idea of how that facility performs. There are some good performing facilities and poor performing facilities. The team coordinator then assigns the tasks to be done to the team members, then every team member knows what they have to do.

When we get to the facility, the team divides up and we all go in different directions, tour the facility and get an overall view of the status of the residents. Next, we meet and select our survey sample based on our observations, information gathered from the tour and the facility staff.

Once the sample of residents is chosen and we have agreed on what care needs we are going to focus on, i.e. restraints, pressure sores, weight loss, etc., we proceed with medical record reviews while keeping our eyes and ears open to the surroundings. We discuss our concerns with the facility staff as we so that there are no surprises at the end of the survey.

The survey is divided into two phases. In Phase I, we do a certain number of comprehensive reviews of the medical record. In Phase II, we do focused reviews, keeping our attention on

those focused issues identified in Phase I, or new issues identified in Phase II .

When all survey tasks are complete, we have an "exit conference" and advise the facility of our findings.

We then write a report regarding the deficient practices and wait for a written response and plan of correction.

We try to write our report in a manner that is most beneficial to the residents. We give our deficient findings a score based on scope and severity. Sometimes money penalties are assessed as a remedy to the deficient practices.

The specific shortfalls that plague the system are:

a. The appointments of Administrative Staff to run the Department of Health Services who do not have a medical background or medical education. They make all the decisions regarding the health care of the elderly. The medical professionals are not always involved in making the final determinations regarding the health care of the elderly in California.

b. The focus is no longer on patient care. The focus appears to be on "warehousing" the elderly, running the facility as cheaply as possible with inferior products, i.e. soaps, linens and overworking the CNA's at lowly wages and double shifts. There are times that CNA's are so tired that they are not able to give appropriate care and accidents result. The residents sustain fractured bones and they are the ones that end up suffering and paying the price.

c. Allowing the Medical Director of a facility to be attending physician for as many as 80-90% of the total population. In some cases, the physician does not get to know the patients, let alone provide adequate care. When the patient suffers or declines in medical status, there is no one above that medical director/attending physician to provide the necessary treatment and services for the patient. The resident continues to go down hill and dies.

d. The State citations and penalties assessed are often reduced to a lower level of severity and to a reduced amount of money because the facility's attorneys complain to the Department or negotiate a settlement at the expense of the patient and/or the families. I do not know how the State citation and penalties are enforced but it appears that many of the penalties are never collected and the facilities continue to operate their business as usual.

e. State regulations are antiquated and have not been revised for years. The regulations are the minimum requirements and do not reflect the current care needs of the elderly in today's society. In many cases, the regulations are so out of date they are obsolete and non-applicable.

The survey teams in the skilled nursing facilities do not usually involve the physician consultant unless there is an "A" citation to be issued. In those cases, the support the team receives from the physician consultant, appears to depend upon which facility is involved. In some cases, there have been interventions in the decisions made at CRC (citation review conference) and those interventions have reversed the results of the hearing officers decision.

The impact that influence, preferential treatment, cronyisrn and favoritism have upon surveyors is that it instills a feeling of frustration, hopelessness, and anger because it negates the intent of the process to regulate and provide appropriate, safe care for the patient. The effort is spent for naught! The providers continue to take advantage of the system at the expense of the patient. Eventually, the surveyors become so complacent, they don't bother to react to the situations and all findings are classified as "unsubstantiated" when, in fact, the opposite is true. The surveyor gives up and asks "what's the use"?

The existence, prevalence and catalyst for malnutrition, dehydration, decubitus ulcers, urinary tract

infections, fractures, burns and scaldings experienced in nursing homes I have inspected is the low nursing staff to patient ratio requirement. The requirements are minimal and totally inadequate for today's population in skilled nursing facilities. The facility can manipulate the staffing figures to meet the requirements, but, that doesn't mean the staffing is adequate at all.

For example, the facility has 4 licensed nurses in 24 hrs., the nurses hours are counted twice. The facility can say they have 8 nurses when, in fact, there are only 4 nurses in 24 hours.

Time and time again, the most prevalent complaint from residents in nursing homes, or their families, is the shortage of staff. Some family members feel compelled to spend every possible moment with their loved ones for fear that he/she won't be cared for. The family member ends up getting sick from the stresses as a result of having their loved one in the facility and the staffing shortages.

In addition, a current problem in California is the inadequate training the CNA's (Certified Nurses Aides) are receiving through those facilities that provide CNA training programs. There are only 3 RN's overseeing the CNA programs in the State of California. The facilities are getting automatic renewals for the programs. There are no provisions for program site visits to ensure that the provider and program is in compliance with the regulations or the facility's own policies and procedures.

Another problem is the requirement of dietary services provided by the registered dietician to the SNF. There are some providers who have as many as 14 facilities for 1 dietician. It is impossible for 1 dietician to oversee the nutritional status of 1,400 residents, if each facility has 100 residents. Some facilities have as many as 250 residents.

The dietary supervisors are not adequately trained to monitor the nutritional requirements of the patients. Significant weight losses and dehydration are sustained by residents before any interventions are implemented by the facility. By the time the dietician gets to the problem, it is too late. The resident may die from dehydration, or breaks down, develops pressure sores which never heal and result in sepsis and death.

It is difficult to choose a worst case of neglect in the California nursing homes I have inspected. I have seen residents with Alzheimer's disease who were beaten to a pulp and their facial bones were all fractured by another resident when the resident wandered into the aggressor's room. I have seen residents who were malnourished, developed Stage III and Stage IV pressure sores, that never healed, became infected and the resident died of sepsis. I have seen instances where the resident fell, fractured her arm, went to surgery, and died within a week from complications related to the initial fall. While the entire facility staff (except for one licensed nurse overseeing 90+ residents) were all attending an inservice regarding falls, another resident left the facility in her wheelchair and was found outside in the parking lot, bleeding from scalp lacerations. 911 was called by a member of the church across the parking lot who confirmed that the resident was out of the facility, found, assisted and transported to the acute care hospital before the facility was aware that the resident was missing. I have seen instances when the attending physician of 80% of the SNF's population was also the medical director of the facility. The residents under the care of that physician were so neglected, many had significant weight losses, infections and died as a result from lack of intervention and care by the physician.

One of the worst cases of neglect in a California nursing home is where an abusive resident was allowed to beat 5 female residents over night. The facility failed to do anything about the situation until the surveyor intervened. The 5 female residents were in the Alzheimer's unit, so the facility thought it was alright to allow the resident to get beaten up because they didn't know what was happening anyway.

We had to call a "serious and immediate" threat before the facility would protect the residents from further harm. Those residents who have no family to visit them are the most vulnerable to neglect because there is no one to oversee their care.

My experience and opinion regarding the motivation of nursing home administrators is MONEY. This is a lucrative business and it is not done for free. Most administrators do not invest any money back into the facility. Many times the residents are observed in tattered and ill-fitting clothes. Their hair is matted and dull because shampoo and conditioner are not used to wash their hair. The facilities use a generic soap for shampooing as well as showering. The wash cloths are paper thin and inadequate. The quality of patient's care is diminished.